

# Powell County Schools Home/Hospital Instruction Application

Please fill out and return to: Powell Co. Board of Education  
Meredith Robinson, DPP  
691 Breckinridge St.  
Stanton, KY 40380  
Phone: 606-663-3300  
Fax: 606-663-3303

Parents,

It is very important that you fill out and return this form to the Powell County Board of Education as quickly as possible. If you can bring it by in person that would be best to ensure your child will miss the least education possible. However, if you are unable to come by our Central Office, please mail the completed form to the above address. We must have the application before we can start counting days of instructional service.

Section I- Completed by the parent before giving it to the doctor.

Section II- Completed by an authorized medical or mental health professional.

Section III- Completed by our office during our review committee meeting.

The first sheet is an agreement letter that the parent/legal guardian must sign before services can begin. We ask that you read and fill this out in the event that the application is accepted.

We look forward to working with you to meet the needs of your child.

Sincerely,  
Meredith Robinson  
Director of Pupil Personnel  
Powell County Schools

**Application for Home/Hospital Instruction**

**June 2021**

(Please type or print neatly)

Parent/Student Information

**Section I**

To be completed by the parent(s)/guardian(s)

School District \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

County of Residence \_\_\_\_\_ Last Date Attended \_\_\_\_\_

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of Student \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Social Security # \_\_\_\_\_ Telephone # \_\_\_\_\_

Full Name of Father/Guardian \_\_\_\_\_ Telephone# \_\_\_\_\_

Full Name of Mother/Guardian \_\_\_\_\_ Telephone# \_\_\_\_\_

Does the student have an Individualized Education Program (IEP)? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the student have a Section 504 Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Directions to student's home \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Pursuant to KRS 158.033(4), eligibility for home or hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) and shall be provided pursuant to the Individualized Education Program (IEP). The ARC chairperson shall provide written notice of home/hospital placement to the local Director of Pupil Personnel (DPP) for purposes of program enrollment using the form in section IV of this application. 702 KAR 7:150.

Pursuant to KRS 159.030(2), before granting any student an exemption from compulsory attendance, the board of education of the district in which the student resides shall require submission to the board of satisfactory evidence in the form of a signed statement of a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the diagnosed condition of the child prevents or renders inadvisable attendance at school and requires home or hospital instruction. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. On the basis of such evidence, the local board of education may exempt the student from compulsory attendance.

A student with a recurring condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply:

- (a) Initial approval by the Review Committee shall be required;
- (b) The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services;

- (c) If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension;
- (d) The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services;
- (e) The Review Committee shall review intermittent placement at least every six (6) months, and at that time a statement from a second professional, shall be required by the Review Committee for continued program eligibility; and
- (f) The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction.

Pregnancy is not considered a physical or health impairment in and of itself, and the nature and extent of any complication shall be delineated prior to consideration of home or hospital instruction for this condition. 702 KAR 7:150.

For students receiving home or hospital instruction pursuant to a determination by a Home or Hospital Review Committee, eligibility shall cease if the student works, plays sports or participates in extracurricular activities. 702 KAR 7:150.

### RELEASE OF INFORMATION

I understand that if the Home/Hospital Review Committee makes the determination of placement for this student, they may request a review of the information provided on these forms by local health personnel. I hereby authorize this committee to have access to pertinent information regarding this request. I understand that if the Admissions and Release Committee makes the determination of placement for this student, they will have access to all pertinent information regarding this request.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Application for Home/Hospital Instruction  
Professional Statement**

**\*\*Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in Section IV shall be used to provide this notice. \*\***

**Section II**

This section is to be filled out by a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the student. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. In order for a district board of education to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires home or hospital instruction.

Name of Student \_\_\_\_\_

\_\_\_\_ I do/ \_\_ I do not support home/hospital instruction for this student. If you do not support home/hospital instruction at this time, please state your concerns and/or recommendations: \_\_\_\_\_

Please check one of the following:

\_\_\_\_ The student can attend school without any type of modifications or special provisions.  
Comments: \_\_\_\_\_

\_\_\_\_ The student can attend school only with modifications or special provisions.  
Describe Modifications Needed: \_\_\_\_\_

\_\_\_\_ The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction. **If checked, please complete the rest of Section II.**

Diagnosis \_\_\_\_\_ Prognosis: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Specific reason (s) why the student is unable to attend school at this time: \_\_\_\_\_

How long have you been seeing the patient for the diagnosis listed? \_\_\_\_\_

Approximate length of time student will need Home/Hospital Instruction \_\_\_\_\_

Recommended start date of Home/Hospital instruction: \_\_\_\_\_

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time.

What is the treatment plan for the patient? \_\_\_\_\_

What is the expected duration of treatment? \_\_\_\_\_

Start date of hospital admission, if applicable: \_\_\_\_\_

Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year. \_\_\_\_\_

What ancillary services are involved in treatment? \_\_\_\_\_

List consultants/specialist to whom this student has been referred.

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will you be following the patient? \_\_\_\_\_ Yes \_\_\_ No. If not, who will? \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

Anticipated date of student's return to school \_\_\_\_\_

What are your recommendations to assist this student in their return to school? \_\_\_\_\_

Remarks/Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Licensed Professional

Title

Date

Please Print or Type Name of Professional: \_\_\_\_\_

Office Address \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Fax Number \_\_\_\_\_

**Application for Home/Hospital Instruction  
Home/Hospital Review Committee**

**Section III**

Name of Student \_\_\_\_\_

Date Application Received: \_\_\_\_\_ Approved \_\_\_\_\_ Denied \_\_\_\_\_ Incomplete\_\_ If  
approved, date of services will be from \_\_\_\_\_ until \_\_\_\_\_  
(Review Date)

If eligibility for services denied, reason for denial \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If incomplete application, type of additional information requested \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Request \_\_\_\_\_ Person Contacted \_\_\_\_\_

**Signatures of Committee Members:**

Director of Pupil Personnel \_\_\_\_\_ Date \_\_\_\_\_

Program Director \_\_\_\_\_ Date \_\_\_\_\_

Home/Hospital Teacher \_\_\_\_\_ Date \_\_\_\_\_

Medical or Mental  
Health Personnel \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Other Relevant Professional \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Application for Home/Hospital Instruction  
Documentation of Admissions and Release Committee (ARC)**

**Section IV**

Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP). The ARC chair shall provide written notice of eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. The form provided in this section shall be used to provide this notice. \*\*

Name of Student \_\_\_\_\_

Does the student have a current/active Individualized Education Program (IEP)?  Yes  No

Start date of home/hospital placement: \_\_\_\_\_

Anticipated end date of home/hospital placement: \_\_\_\_\_

Date of the most recent ARC meeting where Home/Hospital placement was decided: \_\_\_\_\_

Total number of hours of Home/Hospital instruction per week: \_\_\_\_\_

ARC Chair: \_\_\_\_\_

\_\_\_\_\_  
Signature of ARC Chair

\_\_\_\_\_  
Date